IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

April 30, 2007

Kathleen Higley, Administrator
Emeritus Corporation - Ridge Wind Assisted Living
4080 Hawthorne Rd
Chubbuck, ID 83202

Dear Ms. Higley:

On November 8, 2006, a complaint investigation survey was conducted at Emeritus Corporation - Ridge Wind Assisted Living. The survey was conducted by John Wingate, RN, Polly Watt-Geier, MSW and Debra Sholley, LSW. This report outlines the findings of our investigation.

Complaint # ID00002463

Allegation #1: The identified resident is not receiving appropriate care for her edematous, red, sloughing lower extremities.

Findings: Based on observation, interview and record review it was determined the identified resident did have large swollen legs. However, it was determined the resident did receive appropriate care for her lower extremities.

Review of identified resident records on January 16, 2007 - January 17, 2007 document the identified resident receives scheduled hyperbaric treatment from her physician for her lower extremities. Home Health and caregivers at the facility are following physicians orders related to treatments and medications for her lower extremities.

Review of identified resident's records reveals a physicians progress note dated December 27, 2007 that documents "Legs are looking much better".

Observations on January 16, 2007 - January 17, 2007 of identified resident's lower extremities reveal clean, dry and intact dressing wraps bi-laterally.

Observations on January 16, 2007 of photos taken at the identified residents doctors office document improvement of residents lower extremities.

Interviews on January 16, 2007 - January 17, 2007 with the identified resident document the resident feels she is getting good care from all involved. She states "my legs are getting better especially over the last month or so. I have been getting good care here."

Interviews with multiple caregivers reveal that they all know about the basic physicians orders related to caring for the identified residents legs. All interviewed reported that resident is resistant to some orders such as the resident refuses to sleep in bed with feet elevated. She prefers to sleep in a big "cushy" chair instead. Caregivers have discussed the consequences of non-compliance to the orders with the resident. They have contacted physician and family also of non-compliance to physicians orders.

Conclusion: Unsubstantiated. While it was determined the identified resident did have large swollen legs, it was also determined the resident did receive appropriate care for her lower extremities. The facility was not cited as they acted appropriately by offering and providing appropriate care.

This document is an amendment of a previous findings letter sent to the facility. The conclusion statement has been changed to correct an error in wording.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

JOHN WINGATE, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

JW/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R772	A. BUILDING _____ B. WING _____	11/08/2006

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EMERITUS CORPORATION - RIDGE WIND ASS	4080 HAWTHORNE RD CHUBBUCK, ID 83202

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R 000	Initial Comments The following deficiencies were cited during the standard survey and complaint investigation conducted at your residential care/assisted living facility. The surveyors conducting your survey were: Polly Watt-Geier, LSW Team Coordinator Health Facility Surveyor Debbie Sholley, LSW Health Facility Surveyor John Wingate, RN Health Facility Surveyor Survey Definitions: NSA = Negotiated Service Agreement UAI = Uniform Assessment Instrument MAR = Medication Administration Record RN = Licensed Professional Nurse LPN = Licensed Nurse ADL's = Activities of Daily Living mg = milligrams	R 000		
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide sufficient supervision to meet the needs for 4 of 11 sampled residents (#2, #3, #6 and #10) and had the potential to affect 100% of the	R 008		

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R 008	Continued From page 1 residents in the facility. The facility also failed to provide assistance and monitoring of medications for 2 of 11 sampled residents (#8 and # 11). Additionally, the facility failed to implement and update an NSA to reflect the resident's change in condition for 1 of 11 sampled residents (#1). The findings include: 1. Supervision Review of the resident roster matrix, prepared by the facility's RN on 11/1/06, revealed there were a total of 88 residents in the facility. During the tour of the facility on 11/1/06 at 8:45 a.m., the facility was observed to have 3 hallways. Hallway #1 had 30 residents, hallway #2 had 33 residents, and hallway #3 had 25 residents. On 11/1/06 at 10:40 a.m., a resident stated, "they have minimum staff here. It takes way too long for them to give me my morning medications. There have been times when I didn't get them until 11:00 a.m., or later." On 11/1/06 at 1:37 p.m., a second resident stated "when I had as needed pain medications ordered in the middle of the night they sometimes would not have a medication technician in the building, so they would have to call somebody in to give me my pain medications." On 11/2/06 at 10:45 a.m., a staff assisting residents with morning medications stated "I still have morning medications to give and it's almost eleven. I have been busy answering call lights. We don't have enough staff to get everything done on time."	R 008		

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R 008	Continued From page 2 On 11/2/06 at 11:45 a.m., a staff member stated that 1 medication technician and 1 direct caregiver worked on the morning shift at the facility on 11/2/06. She also stated housekeeping staff were directed to carry call light pagers and provide direct care to the residents. She stated the facility was normally staffed with 1 medication technician and 2 direct care providers to meet the needs of the residents. Additionally, she stated there were not enough staff to answer call lights in a timely manner, prevent falls, supervise residents' behaviors or provide assistance with toileting. On 11/2/06 at 11:48 a.m., a second staff member stated she was hired to clean and empty trash. She stated she was directed to provide direct cares to residents and carry a call light pager and that cleaning and trash did not get done on a regular basis. On 11/2/06 at 1:50 p.m., a third staff member stated she had not been trained to provide personal care to residents, however, she had been called in at times to provide personal care to residents when there was not enough trained staff to provide the care. On 11/2/06 at 5:00 p.m., a staff member stated that on 11/1/06 she was called back in to work on the evening shift because the State Surveyors were in the building and there were not enough staff to meet the needs of the residents. On 11/2/06 at 6:45 p.m., the administrator and RN confirmed staff members who were not trained to provide personal care to residents had provided the care. Additionally, they confirmed that occasionally a medication technician was not at the facility at night, but was on call and would	R 008		

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R 008	Continued From page 3 be called back to provide assistance with medication for the residents who needed medications during the night. Call Lights Review of the facility's complaint log on 11/2/06 revealed a complaint dated 2/8/06. It documented the residents had been concerned about call light response time. The administrator checked the call light responses and found the average time to be 5 to 7 minutes. It also documented the administrator would continue to monitor call light response and have nursing staff assist with answering call lights. Additionally, a complaint response letter written on 9/15/06 documented the facility had replaced broken pagers, added a pager which would be monitored by the nursing staff, an in-service had been held with caregivers to discuss "the importance of answering the call lights immediately" and the administrator would follow up with caregivers to assure the call lights were being answered in a timely manner. On 11/1/06 at 1:33 p.m., a resident confirmed that on multiple occasions she had to wait 30 to 40 minutes or more before staff answered her call light page. On 11/1/06 at 3:30 p.m., a resident's family member stated she had personally witnessed her mother push her call light and it was at least 30 minutes before staff responded to her call light. On 11/2/06 at 10:45 a.m., two caregivers stated "the administrator wants us to answer the residents pages within 7 minutes but we don't have enough staff to do that." On 11/2/06 at 1:38 p.m., a second resident's	R 008		

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R 008	Continued From page 4 family member stated that "staff can take quite awhile before they check on her." On 11/2/06 at 2:27 p.m., another resident stated "there have been many times where I have had to wait 30 minutes or more before anyone answered my page." On 11/3/06 at 10:30 a.m., the facility administrator stated "we would like staff to answer pages within 5-7 minutes." On 11/6/06 at 11:14 a.m., a third resident's family member stated "there have been times where it has taken up to an hour before staff answered mom's page." Falls 1. Review of Resident #2's record on 11/1/06 documented the resident was admitted on 9/7/04 with diagnoses which include dementia, history of multiple falls, history of lumbar fractures and a recent right hip fracture. Resident #2's record contained a combined UAI/NSA dated 6/2/06. It documented that caregivers needed to monitor the resident closely due to her multiple falls. A section titled "Mobility & Transferability" document the resident was "too unsteady to walk more than a couple of steps." Finally it documents the resident as being "unable to move with or without assistive devices; staff must move resident." Review of the facility's records revealed a document titled "Daily Log Report" dated on 10/10/06 at 11:00 p.m., it documented "Caregiver found resident on the floor, she complained of back pain and stated she did not	R 008		

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R 008	Continued From page 5 hit her head." The note ended with "The resident forgets that she can't stand or transfer without assistance, and forgets to use call light." Further review of the facility's "Daily Log Report" revealed that on 10/12/06 at 11:00 p.m., a caregiver heard the resident yelling and found her lying on the floor. The resident told the caregiver that she had fallen out of bed. The progress note documented "the resident will be checked every 2 hours, changed and repositioned for comfort." On 11/1/06 and 11/2/06 the resident was observed to need total assistance with mobility from staff and family. On 11/2/06 at 2:28 p.m., the residents family member stated "sometimes I think she falls because she has to go to the bathroom." 2. Review of Resident #3's record on 11/1/06 revealed the resident was admitted on 7/9/05 with diagnoses of hypertension, stroke, pacemaker, and deep vein thrombosis. Resident #3's record contained a combined UAI/NSA dated 10/28/06. The section titled "Mobility & Transferability" documented "the resident was able to move inside or outside with assistive device; needs staff monitoring." Review of the facility's document entitled "Event/Incident Report" revealed the resident had an unwitnessed fall on 9/30/06 at 3:45 a.m. It documented a "caregiver observed resident on the floor in the bathroom next to the toilet. Resident stated she fell down when trying to pull down her underpants." On 11/2/06 at 2:20 p.m., the resident stated "I've	R 008		

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R 008	Continued From page 6 had multiple falls because staff wait so long to answer pages. On one occasion it took staff an hour before they answered my call. I could not wait any longer to urinate so I tried to get up and go to the bathroom myself and I fell." Toileting 1. Review of Resident #6's record on 11/1/06 documented the resident was admitted on 8/30/06 with diagnoses of non insulin dependent diabetes mellitus, decreased mobility related to spinal stenosis, sleep apnea, myocardial infarction, pulmonary emboli, and asthma. The resident's record contained a combined UAI/NSA dated 10/28/06. The section titled "Mobility & Transferability" documented; "resident is able to meet most of her toileting needs; requires standby assistance or cueing for safety or task completion; may need some physical assistance with parts of the task such as assisting with attends, clothing adjustment, washing hands etc." Review of the facility's progress notes dated 9/21/06 documented that she had a fall and fractured her left arm. The document further added that resident will need to wear a shoulder immobilizer at all times. Review of progress note dated 9/26/06 documented; "residents roommate informed nurse that the resident is requesting extensive help with ADL's. Roommate complained that this is causing hardship for her. Resident is requesting help with all ADL's, standby assist with when walking due to her inability to use her walker while her arm is immobilized."	R 008		

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R 008	Continued From page 7 On 11/1/06 at 1:30p.m., the resident was observed with an arm immobilizer on her left arm and confirmed she required assistance with ADL's and toileting. On 11/2/06 at 3:15 p.m., the resident stated "I have waited 30-40 minutes sitting on the toilet before staff answered my page. A couple of weeks ago I sat on the toilet for over an hour. My roommate, who needed to use our toilet, was unable to help me get off the toilet. My roommate couldn't wait any longer and ended going outside and defecating on the side of the building." On 11/2/06 at 3:23 p.m., the resident's roommate confirmed that she was forced to defecate outside of the building due to staff "taking an hour" to answer the page. 2. Review of Resident #3's record on 11/1/06 revealed the resident was admitted on 7/9/05 with diagnoses of hypertension, stroke, pacemaker, and deep vein thrombosis. Resident #3's record contained a combined UAI/NSA dated 10/28/06. The section titled "Mobility & Transferability" documented "the resident was able to move inside or outside with assistive device; needs staff monitoring." Review of the facility's record revealed a document titled "Event/Incident Report" dated 9/30/06 at 3:45 a.m. It documented that Resident #3 had an unwitnessed fall and that the caregiver found resident on the floor of the bathroom. On 11/2/06 at 2:20 p.m., the resident stated "I have had multiple falls because staff wait so long to answer pages. On one occasion it took staff an hour before they answered my call."	R 008		

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R 008	Continued From page 8 I could not wait any longer to urinate so I tried to get up and go to the bathroom myself and I fell. Behaviors 1. Review of Resident #10's record revealed the resident was admitted on 6/9/04 with a diagnosis which included Alzheimer's. Review of Resident #10's record on 11/2/06 revealed a combined UAI/NSA dated 10/8/06 which documented the resident would wander into other residents rooms. Additionally, it documented the other residents would become angry when she wandered into their rooms. Review of the facility's incident and accident reports on 11/1/06 revealed the following documentation: On 8/7/06 at 9:30 a.m., a caregiver entered a resident's room because she heard yelling. The caregiver saw a resident yelling at Resident #10 with his hands around her neck. On 9/30/06 at 3:00 p.m., Resident #10 was slapped in the face by another resident. Review of the facility's progress notes on 11/3/06 revealed the following documentation: On 9/5/06, Resident #10 had increased confusion, periods of anxiety and agitation that staff have not been able to redirect. On 10/1/06, Resident #10 became intrusive and angry and slapped a resident, the resident slapped Resident #10 back. On 10/13/06, Resident #10 had increased	R 008		

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R 008	Continued From page 9 confusion and wandering. On 10/14/06, Resident #10 wandered throughout the facility and needed to be oriented several times during the day. On 10/20/06, Resident #10 was confused, she was redirected with "short-term results." Resident #10's record contained a document entitled "ABC Behavior Management" which documented the following: On 10/16/06, the resident became angry and yelled and hit residents and caregivers. On 10/19/06, the resident went into other resident rooms at night, sat on their beds or woke them up. Further review of Resident 10's record on 11/3/06 revealed a document entitled "Physician/Consultant Visit-Notes and Orders" which documented the following: On 8/16/06, the resident was anxious and restless in the evening. She was unable to settle down and sleep. She bothered other residents in their rooms. On 10/13/06, the resident wandered into residents rooms, slammed the doors shut and sat down on their beds. Additionally, it documented the other residents were frightened by the experience of the resident wandering into their bedrooms. On 10/19/06, the resident had been up wandering at night, entering other residents rooms and "she has been intrusive and is raising her cane to	R 008		

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R 008	Continued From page 10 residents." On 11/1/06 at 3:49 p.m., a resident stated that Resident #10 wandered throughout the facility and into other residents' rooms. On 11/1/06 at 4:23 p.m., a second resident stated that Resident #10 wandered throughout the facility and into residents' rooms. He stated the Resident #10 had entered his room about 2 weeks ago at 10:00 p.m., and woke him from his sleep. He also stated the resident had entered his room 3 additional times. On 11/2/06 at 10:35 a.m., the Resident #10 was observed leaving another resident's room and stuffing mail into her pockets. Staff were not observed to redirect the Resident #10 at that time. On 11/2/06 at 11:26 a.m., the Resident #10 was observed wandering through the facility. Staff were not observed to re-direct the resident. On 11/2/06 at 11:45 a.m., a caregiver stated Resident #10 wandered into other residents' rooms. She also stated Resident #10 would become angry and aggressive with staff and residents. Additionally, she stated when Resident #10 wandered, staff would not try to re-direct her as she would become aggressive towards staff. On 11/3/06 at 10:00 a.m., the administrator stated the resident's dementia had progressed. Additionally, she stated the resident had become intrusive with other residents. The facility did not provide sufficient supervision to assure residents' health, safety and comfort was provided for at all times by answering call	R 008		

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R 008	Continued From page 11 lights in a timely manner, providing interventions to prevent falls, providing assistance with toileting, and by re-directing a resident who wandered into other residents' rooms and who became physically aggressive with staff and other residents. These failures affected Residents #2, #3, #6, #10 and potentially 100% of the residents in the facility. 2. Assistance and Monitoring of Medications 1. Review of Resident #8's record revealed the resident was admitted on 5/2/05 with a diagnosis which included infrarenal abdominal aortic aneurysm. Review of Resident #8's record on 11/1/06 revealed a combined UAI/NSA dated 8/2/06 which documented the resident needed assistance with medications as prescribed by his physician. Further review of Resident #8's record revealed a physician order dated 9/25/06 that documented the resident was to take: lisinopril 20 mg by mouth daily. The resident's record contained a progress note dated 9/26/06 which documented the resident's physician had ordered lisinopril 20 mg by mouth daily. Review of the facility's September 26, 2006 through November 1, 2006 MAR revealed the resident received lisinopril 20 mg twice daily. On 11/2/06 at 5:40 p.m., the facility's licensed professional nurse confirmed the resident had been receiving lisinopril 20 mg twice daily after	R 008		

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R 008	Continued From page 12 the physician or authorized provider had ordered lisinopril 20 mg once daily. 2. Review of Resident #11's record revealed the resident was admitted on 9/1/06 with a diagnosis which included Biplor disorder. Review of Resident #11's record on 11/2/06 revealed a combined UAI/NSA dated 10/28/06 which documented the resident needed assistance with medications as prescribed by the physician. Further review of Resident #11's record revealed a physician order dated 9/1/06 which documented the resident was to take: Topamax 25 mg twice daily Depakote 500 mg twice daily Synthroid 15 mg once daily Effexor XR 150 mg twice daily metformin 1000 mg twice daily Premarin 0.625 mg once daily On 11/2/06 at 3:56 p.m., the resident was observed standing beside the medication cart talking with a staff member and stated "how do I get my morning medications around here?" Review of the resident's October 2006 MAR on 11/2/06 revealed the resident was out of the facility (OOF) on the mornings of 10/1, 10/2, 10/7, 10/13, 10/14, 10/15, 10/18, 10/20, 10/21, 10/22, 10/23, 10/28, 10/29, 10/30, and 10/31. Review of the resident's November 2006 MAR revealed the resident was out of the facility on the morning of 11/2/06. On 11/2/06 at 6:13 p.m., the resident's	R 008		

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	13R772	A. BUILDING _____ B. WING _____	11/08/2006

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R 008	Continued From page 13 medication bubble packs was observed to contain medications from the morning of 11/2/06. On 11/2/06 at 6:14 p.m., the LPN confirmed the resident did not receive the 11/2/06 morning medications. On 11/3/06 at 8:46 a.m., the resident stated she had not been assisted with her morning medications on a regular basis. She stated she had to leave the facility at 10:30 a.m., in the mornings to go to group. She also stated if she had not been assisted with her morning medications before going to group, she would not receive them. Additionally, she stated she had been more tired than normal because she had not received her medications as ordered by her physician or authorized provider. On 11/3/06 at 10:00 a.m., the facility's RN denied the resident had not been assisted with medications as prescribed by her physician or authorized provider. She stated when a MAR documented a resident was out of facility (OOF) it meant the resident's medications were given or taken with them when they left the facility. Review of the facility's October 2006 "Medication Destruction Record" revealed the following medications were destroyed: 4 Topamax, 1 Synthroid, 4 Premarin, 7 metformin, 1 Effexor, and 4 Depakote. The "Medication Destruction Record" further documented the reason for the destruction of medications had been due to the resident being out of the building (OOB). The facility failed to provide assistance and	R 008		

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R 008	Continued From page 14 monitoring of medications when it failed to assure Resident #8 and Resident #10 were assisted with his medications as ordered by thier physician or authorized provider. 3. Failure to update and implement NSA 1. Review of Resident #1's record on 11/1/06 revealed the resident was admitted on 4/1/02 with diagnoses that included hypothyroidism, osteoporosis and chronic back pain. Review of Resident #1's NSA dated 10/27/06 revealed the resident was able to feed herself but needed constant supervision and assistance to ensure safety and adequate intake. Additionally, it was documented the resident had occasional gagging, choking, or swallowing difficulty, and required assistance with feeding utensils. On 11/1/06 at 10:30 a.m., a breakfast tray was observed at the bedside table in Resident #1's room. The breakfast tray was observed sitting on the counter in the resident's room and the food was covered and did not appear the resident had been assisted with her meal. The lights were off, and the resident was observed to be lying on her back sleeping. On 11/1/06 at 10:30 a.m., the administrator stated the resident "sometimes" needed assistance to eat and "sometimes" she refused to eat. "Most of the time she sleeps" On 11/1/06 at 12:15 p.m., the LPN stated that around the middle of September the resident began to decline and refused to eat most of the time. On 11/1/06 at 3:30 p.m., Resident #1's family	R 008		

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R 008	Continued From page 15 member stated there had been a rapid decline in the resident's memory in the last 6 weeks. She stated the resident was not able to remember to eat, and required total assistance from staff to assist her with eating and drinking. Additionally, she stated the resident had a significant weight loss in the last 6 weeks. She stated the resident could not remember her food tray was sitting on the table next to her bed, and the resident was not able to reposition herself in bed and no longer had the physical strength to remove the food tray from the bedside table and place it on her lap to eat her meals. On 11/2/06 at 2:30 p.m., 4 random staff members interviewed stated Resident #1 required total assistance with eating, required staff to wake her up, needed reminded to eat and drink and required assistance with using eating utensils. Additionally, they stated they had not been instructed to go into the resident's room during meal times and assist her with eating, however they would walk by the resident's room during the day and try to get her to eat and drink. Review of the resident's "Monthly Vital Signs and Weights" chart for 2006 revealed the resident weighed 107 lbs in January, 2006 and weighed 99 lbs by April, 2006. There was no documented evidence of the resident's weight after August 2006. Review of the facility's "Change of Condition" policy documented "A change of condition may include but not limited to changes in the physical, mental or psychosocial well being of the resident that is either acute in nature or a condition which lasts longer than 14 days". The policy further documented that at the end of 14 days either the resident would be able to assume their previous	R 008		

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R 008	Continued From page 16 level of functioning or a new assessment would be completed to acknowledge the change of condition. Additionally, the policy documented a "Service Meeting" would be held with the resident and the resident's responsible party to acknowledge the change in the resident's condition and formulate a new service and care plan. Further review of the resident's record on 11/2/06 revealed no documented evidence the NSA had been updated to reflect the increased care needs for assistance with meals. On 11/2/06 at 7:00 p.m. the administrator and the licensed nurse confirmed there had been significant changes in the resident's needs between mid- September 2006 and October 31, 2006. The facility failed to provided sufficient supervision to assure residents' health, safety and comfort was provided for at all times for Residents #2, #3, #6, #10 and potentially 100% of the residents in the facility. The facility failed to provide assistance and monitoring of medications for Residents #8 and #11. Additionally, the facility failed to implement and update the NSA to reflect the resident's change in condition and guide personnel to meet the needs of Resident #1. These failures resulted in inadequate care.	R 008		
R 009	16.03.22.525 Protect Residents from Neglect. The administrator must assure that policies and procedures are implemented to assure that all residents are free from neglect. This Rule is not met as evidenced by:	R 009		

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R 009	Continued From page 17 Based on observation, interview and record review, it was determined that the facility failed to implement policies and procedures to protect 1 of 11 sampled residents from neglect. The findings include: Review of Resident #2's record 11/1/06 revealed the resident was admitted on 9/7/04 with diagnosis of dementia, a history of falls, lumbar fractures and a right hip fracture. On 11/1/06 between 1:34 p.m., and 4:20 p.m., the resident was observed slumped down in her chair with her false teeth laying on her stomache and her nasal cannula lying on her shoulder. The resident's room smelled of urine. On 11/2/06 at 1:38 p.m., the resident's family member stated "We come in every other day to visit her. She usually is incontinent of urine and sitting in the chair when we arrive. About a week ago the hospice nurse called me and told us that when she arrived to check on the resident her whole backside up to her shoulders was soaked with urine." On 11/2/06 at 2:28 p.m., the room smelled of urine. On 11/2/06 at 4:24 p.m., review of the facility's policy and procedures revealed a section titled "ABUSE or NEGLECT." The document revealed that "All alleged abuse or neglect is investigated by the Executive Director and reported in a timely manner." The document further states "examples of neglect, being left to sit or lie in urine or feces." On 11/8/06 at 12:46 p.m., The resident's hospice nurse confirmed that approximately 2 weeks ago	R 009		

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R 009	Continued From page 18 she had found resident sitting in her chair at 4:00p.m. When the nurse and a facility caregiver went to assist the resident the nurse found that residents gown and chair were saturated with urine. The nurse while changing and cleaning the resident found that residents attends had a time of 5:00 a.m written on them. The nurse stated "the resident had been in those attends for at least eleven hours." The facility failed to implement its policies and procedures to protect Resident #2 from neglect by leaving the resident to sit in urine for an extended amount of time on multiple occassions.	R 009		